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Patient's Name _____ Date _____

Musculoskeletal Screening Questionnaire

One or more of the following symptoms may be indicative of musculoskeletal dysfunction of the head and neck.

- If you have any of the following symptoms, please indicate by checking the appropriate are
- | | | | |
|--|------------|--------------------------------------|------------|
| a. Pain in the jaw joint | _____ | r. Headache | __Yes No__ |
| b. Pain in ear | _____ | tensions headaches | __Yes No__ |
| c. Pain around eyes | _____ | migraines | __Yes No__ |
| d. Pain in lower jaw | __L R__ | how often? | _____ |
| e. Pain in upper jaw | __L R__ | top of head | __Yes No__ |
| f. Pain in neck | __L R__ | forehead | __Yes No__ |
| g. Pain in shoulder | __L R__ | back of head | __Yes No__ |
| h. Pain in forehead | __L R__ | temples | __Yes No__ |
| i. Pain in temples | __L R__ | behind eyes | __Yes No__ |
| j. Pain in facial muscles | __L R__ | s. Partial inability to open mouth | __Yes No__ |
| | | If yes, is it (1) Constant _ | |
| | | (2) Sporadic _ | |
| k. Facial muscle twitch | __L R__ | t. Difficulty chewing | __Yes No__ |
| l. Subjective hearing loss | __L R__ | u. Difficulty swallowing | __Yes No__ |
| m. Clicking or popping sound in joint (circle which sounds most descriptive) | __L R__ | v. Pain in tongue | __Yes No__ |
| n. Grating sound in joint | __L R__ | w. Difficulty breathing through nose | __Yes No__ |
| o. Dizziness (vertigo) | _____ | x. Loud Snoring | __Yes No__ |
| p. Ringing sound in ears | __L R__ | y. Constantly tired | __Yes No__ |
| q. Fullness, pressure blockage in the ear | __Yes No__ | z. Mouth breather at night | __Yes No__ |
| | __L R__ | | |
| aa. Awaken with a dry mouth | __L R__ | | |
| If yes, (1) Frequently _ | | | |
| (2) Rarely _ | | | |
| | __Yes No__ | | |
| bb. Loose teeth (specify) _____ | | | |

Occlusal Habits:

- Clenching ___AM ___PM
- Teeth hit in front first
- Gum chewing
- Pencil biting
- Other: _____

- Grinding on teeth ___AM ___PM
- Cheek Biting
- Pipe smoking
- Nail biting

Postural Habits:

- Phone cradling
- TV watching
- Shoulder bag
- Other: _____

- Leans chin on hand
- Heavy lifting

1. What are your chief complaints? List from most to least important.

- a. _____
- b. _____
- c. _____

Other symptoms (please write in) _____

2. Do symptoms affect one or both joints? Right ___ Left ___ Both ___

If both joints, indicate which joint seems most affected Right ___ Left ___ _Yes No_

3. How many years, months, weeks or days have you been bothered by this problem? _Yes No_

a. _____years b. _____months c. _____weeks d. _____days _Yes No_

4. Have you had any injury to the jaw or face? _Yes No_

5. Do you have arthritis? _Yes No_

6. Have you ever had cervical traction?

7. Have you ever worn a neck brace?

8. Have you had any other treatment for this problem? _Yes No_

(If yes, explain-medicine, dental appliances such as a splint, orthotic, or night guard) _Yes No_

_____ _Yes No_

9. Have you had your teeth straightened (orthodontia)? _Yes No_

10. Have you had teeth removed for orthodontia? _Yes No_

11. Have you had your wisdom teeth removed? _Yes No_

12. Have you ever had general anesthesia?

13. Did you have allergies as a child? _Yes No_

14. Have you had your bite adjusted by your dentist?

(equilibration) If yes, explain when _____ _Yes No_

15. Do you attribute the symptoms to any one incident? _Yes No_

If yes, explain _____ _Yes No_

_____ _Yes No_

16. Have you had cortisone injected into your joint?

If yes, when? _____ How many injections? _____

17. Are you now on any medication?

If yes, what kind and how much? _____

Yes No

Yes No

Yes No

18. Do you know if you clench your teeth?

19. Has anyone mentioned that you grind your teeth (brux) at night during sleep?

20. Do you chew gum?

21. Please list chronologically, names and types of doctors and their locations, whom you have seen in the past for this or related pro **Type** **Address**

Write on back of this sheet if necessary.

Date visited

Name

22. In your opinion, what initiated your present condition (chief complaint)?

23. What aspect of your condition concerns you most?

24. Please write in any other pertinent information that has not been covered previously.

Write on the back of this sheet if necessary.
